REGIONAL COMMITTEE FOR AFRICA **ORIGINAL: ENGLISH**

Fifty-ninth session
Kigali, Republic of Rwanda, 31 August–4 September 2009

Provisional agenda item 8

REPORT OF THE PROGRAMME SUBCOMMITTEE

CONTENTS

SECTION I

SECTION II

Page

DRAFT RESOLUTIONS

APPENDIXES

OPENING OF THE MEETING

1. The Programme Subcommittee met in Libreville, Republic of Gabon, from 2 to 5 June 2009.

2. The Regional Director, Dr Luis Gomes Sambo, welcomed the members of the Programme Subcommittee (PSC) and members of the WHO Executive Board from the African Region.

3. The Regional Director indicated that the Programme Subcommittee meeting was taking place at a time of heightened global concern due to the spread of Influenza A (H1N1) and stressed the need for enhanced surveillance. Although there had not been any laboratory-confirmed cases in the Region, it was important for countries to strengthen their contingency and epidemic preparedness and response plans for sustained disease surveillance and early detection in order to forestall any epidemic.

4. He observed that countries in the Region were already grappling with the challenges of communicable and noncommunicable diseases, poverty and weak health systems within the context of the global economic crisis and called for intensified and concerted efforts to address health problems in the Region.

5. The Regional Director emphasized the role and importance of the Programme Subcommittee in making significant contributions to the work of the Organization by critically examining the technical documents and putting forward innovative ideas and concrete proposals for consideration by the Regional Committee. He indicated that the current session of the Programme Subcommittee would discuss key public health issues such as the Influenza A (H1N1) virus, Neglected Tropical Diseases, Health System Strengthening, the Millennium Development Goals, orientations for implementing the WHO Programme Budget 2010-2011 in the African Region, and establishment of Centres of Excellence for disease surveillance, public health laboratories, food and medicines regulation.

6. In concluding his opening remarks, the Regional Director said he was confident that members of the Programme Subcommittee would thoroughly review the technical documents and make action-oriented recommendations to guide the forthcoming Regional Committee towards improving health in the Region. He called on the Subcommittee to propose concrete solutions that took into account the shared interest and realities of all the countries in the African Region.

7. After the introduction of the members of the Programme Subcommittee and the Secretariat of the Regional Office, and some administrative announcements and security briefing, the bureau was constituted as follows:

Chairman:	Dr Souleymane Sanou, Burkina Faso
Vice-Chairman:	Dr George Amofah, Ghana
Rapporteurs:	Mr Setshwano S Mokgweetsinyana, Botswana (for English)
	Dr Félix Bledi Trouin, Cote d'Ivoire (for French)
	Dr Ildo A.S. Carvalho, Cape Verde (for Portuguese).

8. The list of participants is attached herewith as Appendix 1.

9. The Chairman thanked the members of the Programme Subcommittee for the confidence placed in him and asked for the active participation of members to contribute to the success of the meeting.

10. The proposed agenda (Appendix 2) and the programme of work (Appendix 3) were discussed. The proposal by the Regional Director for the inclusion of an item on elimination of measles in the African Region by 2020 was accepted by the Programme Subcommittee.

11. The agenda was adopted with the proposed amendments as stated above. The following working hours were then agreed upon:

9.00 a.m.–12.30 p.m., including a 30-minute tea/coffee break
12.30 p.m.–2.00 p.m. lunch break
2.00 p.m.–5.30 p.m., including a 30-minute tea/coffee break.

TOWARDS REACHING HEALTH-RELATED MILLENNIUM DEVELOPMENT GOALS: PROGRESS REPORT AND WAY FORWARD (Document AFR/RC59/PSC/3)

12. The report provided an update on the progress made towards the achievement of the health-related Millennium Development Goals (MDGs), identified the main challenges and proposed a way forward. The analysis of progress was based on data from the United Nations Statistical Division and *World Health Statistics 2008* and trends were assessed on the basis of data between 1990 and the most recent year for which information was available as of June 2008.

13. Most countries in the African Region had not made sufficient progress towards achieving the MDG targets. Only five countries were on track to achieve Goal 4 (Reduce child mortality). Estimates of maternal mortality ratio for 2005 indicated that the Region had made no progress towards achieving Goal 5. Only a third of the population with advanced HIV infection in the Region had access to antiretrovirals in 2007 (Goal 6). While there were increases in the proportions of under-five children sleeping under insecticide-treated nets between 1999 and 2006 in all 18 countries with trend data, coverage rates were lower than 50% (Goal 6). Only two countries were on track to achieve the target for tuberculosis. Nine countries were on track to achieve the target for safe drinking water while only two countries were on track to achieve the target for basic sanitation (Goal 7).

14. Key challenges that countries needed to address in order to attain the MDGs included inadequate resources, weak health systems, inequities in access to proven interventions, weak multisectoral response, low priority accorded to health in national economic and development policies and inadequate trend data for a number of indicators.

15. Actions proposed included allocating at least 15 per cent of public expenditure to the health sector as set out in the 2001 Abuja Declaration; strengthening health systems by fully implementing the 2008 Ouagadougou Declaration on Primary Health Care and Health Systems in Africa; increasing attention to areas where progress had been limited; strengthening

international partnerships; leadership and institutional capacity; improving the monitoring of progress towards achieving the MDGs; and adhering to the "Three Ones" principle which aims to achieve the most effective and efficient use of resources and ensure rapid action and results-based management through establishing **One** agreed Action Framework that provides the basis for coordinating the work of all partners; **One** National Coordinating Authority with a broad-based multisectoral mandate; and **One** country-level Monitoring and Evaluation System.

16. Members of the Programme Subcommittee observed that there was need to use more recent data to assess progress towards the attainment of the MDGs, particularly the recent results of Demographic and Health Surveys (DHS) from several countries. Lack of progress was noted to be most marked for MDG5 - reduction of maternal mortality. Concerning MDG 4, it was observed that deaths in children under 1 year were still a problem and called for disaggregation of the data. Other causes of child mortality such as some neglected diseases like sickle-cell anaemia should be addressed.

17. The PSC expressed concern on the current limitations of health resources and call for a more efficient use of the existing resources. It was observed that the 15% Abuja target might not be enough to achieve the MDGs. Concern was also expressed about the negative impact of security situations in some countries on health services delivery. It was recommended that the trends for the health-related MDGs should be presented separately from the others in the document in order to give prominence to those that are the primary responsibility of ministries of health.

18. Members of the Programme Subcommittee also made specific recommendations on the content and formulation of the document.

19. In response, the Secretariat indicated that the assessment of progress toward the MDGs followed standard methodologies using the globally agreed indicators to allow comparisons between countries. The latest available data beyond June 2008 should be used to revise the document. The current efforts by the Regional Office to generate and share evidence and best practices in public health were recalled. The importance of keeping the 15% Abuja target was stressed as a good indicator of the level of commitment by countries.

20. The Secretariat reminded the meeting that the accuracy, updating and periodicity of data reporting depended on the functionality of national health information systems. The development of the African Health Observatory would facilitate data collection and reporting on the MDGs. The need to adopt the health systems strengthening approach as a way to scale up proven interventions to meet the health MDGs was reiterated.

21. The Programme Subcommittee agreed to submit the amended document on the subject for adoption by the Regional Committee at its fifty-ninth session.

FRAMEWORK FOR THE IMPLEMENTATION OF THE OUAGADOUGOU DECLARATION ON PRIMARY HEALTH CARE AND HEALTH SYSTEMS IN AFRICA: ACHIEVING BETTER HEALTH FOR AFRICA IN THE NEW MILLENNIUM (Document AFR/RC59/PSC/4)

22. The document recalled that the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa focuses on nine major priority areas. These areas are leadership and governance for health; health services delivery; human resources for health (HRH); health financing; health information; health technologies; community ownership and participation; partnership for health development; and research for health. The Framework proposed recommendations for each of these priority areas except for health information and research for health since these two priority areas had been taken into account in the Framework for implementation of the Algiers Declaration.

23. Among the recommendations for strengthening ***leadership and governance for health*** are institutionalizing intersectoral action for improving health outcomes; updating comprehensive National Health Policy in line with the Primary Health Care (PHC) approach and other regional strategies; updating the national health strategic plan; and providing comprehensive essential health services. To improve the effectiveness of ***health services delivery***, countries needed to provide comprehensive, integrated, appropriate and effective essential health services; design their models of delivery that were people-centred and estimate costs; and ensure service organization and stakeholder coordination to promote and improve efficiency and equity.

24. To improve ***management of human resources for health (HRH)***, countries should develop comprehensive evidence-based health workforce policies and plans; build health training institutions' capacity to scale up the training of relevant health care providers; build HRH management and leadership capacity; and mobilize resources for development of HRH. To improve ***health system financing***, countries should develop comprehensive health financing policies and plans; institutionalize national health accounts and efficiency monitoring; strengthen financial management skills at all levels; and implement the Paris Declaration on Aid Harmonization and Effectiveness.

25. In regard to ***health technologies***, countries should increase access to quality and safe health technologies; develop national policies and plans on health technologies; increase access to quality traditional medicines; develop norms and standards for the selection, use and management of appropriate health technologies; and institute a transparent and reliable system for the procurement of health technologies. For effective ***community participation*** in health development, countries should create an enabling policy framework for community participation; build community capacity; reorient the health service delivery system to improve community access and utilization; and use health promotion strategies to empower communities to adopt healthier lifestyles.

26. To strengthen ***partnerships*** for health development, countries may use mechanisms such as International Health Partnership Plus (IHP+) and Harmonization for Health in Africa to promote harmonization and alignment in line with the PHC approach; and adopt intersectoral

collaboration, public–private partnership and civil society participation in policy formulation and service delivery.

27. Members of the Programme Subcommittee welcomed the Framework as a practical guide for countries to operationalize the Declaration. They appreciated its holistic approach and recognized the pivotal role of human resources for health in the proper implementation of the Framework and the need to promote measures for their motivation and retention. Considering PHC as an approach, instead of as a level of care, will facilitate common understanding of countries for health systems strengthening. Strengthening referral systems will contribute to sustained improvement of health care irrespective of the design of the health system. Annex 1 to the Framework which is an example of translating the proposed recommendations into interventions and actions at country level by priority area was considered as relevant for guiding countries.

28. Members of the Programme Subcommittee made specific recommendations on the content and formulation of the document which the Secretariat agreed to incorporate for finalization of the document.

29. The Secretariat appreciated that members of the Subcommittee agreed on the format and content of the Framework. The Secretariat thanked the members of the Programme Subcommittee for their comments and suggestions and emphasized the importance of country ownership and leadership in the process of implementing the Framework. Concerning intersectoral collaboration, there was need to strengthen national intersectoral health committees taking into account the current context of PHC renewal including the social determinants of health. On the issue of formulating indicators for monitoring the implementation of the Ouagadougou Declaration, it was agreed that there was need to go beyond the MDGs and to include other relevant indicators. It was underscored that the 15% national budget allocation to health and the US$ 34 to 40 annual per capita health expenditure were complementary to each other. Countries were urged to meet the commitment to allocate 15% of national budget to health, and seek partner support to reach the US$ 34 to 40 per capita health spending.

30. The Programme Subcommittee agreed to submit the amended document for adoption by the Regional Committee at its fifty-ninth session.

FRAMEWORK FOR THE IMPLEMENTATION OF THE ALGIERS DECLARATION ON RESEARCH FOR HEALTH IN THE AFRICAN REGION
(Document AFR/RC59/PSC/5)

31. The Framework recalled that the Algiers Declaration, which was adopted during the Ministerial Conference on Research for Health in the African Region, held in June 2008, renewed the commitment of Member States to strengthen national health research, information and knowledge management systems to improve health in Africa. The document aimed to provide countries with a framework to facilitate implementation of the Declaration.

32. Actions proposed for ***strengthening leadership and coordination*** included establishing a broad multidisciplinary national working group; establishing a health research, information and

knowledge management unit within the ministry of health; conducting a situation analysis; developing national policies and strategic plans; establishing or strengthening cooperation mechanisms such as public-private, South-South and North-South partnerships; and creating regional centres of excellence.

33. Actions proposed for ***improving the availability and quality of health information and evidence*** included identification and integration of existing sources of reliable information; instituting procedures to ensure the availability of quality information; increasing the frequency of national demographic and health surveys; completing the 2010 census round; strengthening vital registration, surveillance and service statistics; improving the management of health information; promoting innovative research and the use of systematic reviews; and strengthening institutional mechanisms for ethical and scientific reviews.

34. Actions proposed for ***better dissemination and sharing of information, evidence and knowledge*** included supporting the establishment of health libraries and information centres; ensuring the availability of printed and electronic materials in appropriate formats and languages; publishing existing evidence on health systems and facilitating knowledge generation in priority areas; establishing mechanisms for documenting experiential knowledge and best practices; and ensuring that local publications were included in relevant international indexes.

35. Actions proposed for ***improved use of information, evidence and knowledge*** included ensuring that policy-makers and decision-makers were part of the agenda-setting process; improving their capacity to access and apply evidence; improving the sharing and application of information, evidence and experiential knowledge; promoting regional and country networks of researchers, decision-makers, and policy-makers; and promoting translational and operational research.

36. Actions proposed for ***better access to existing global health information, evidence and knowledge*** included promoting wider use of indexes; improving the use of expertise locators and social networks; and promoting open-access journals and institutional access to copyrighted publications. Actions proposed for ***wider use of information and communication technologies for health (eHealth)*** included evaluating available technologies to identify those that met local demands; ensuring interoperability between various systems; and developing web-based applications and databases.

37. Actions proposed for ***improved human resources*** included capacity strengthening; provision of continuing professional education; and creation of an enabling environment for attracting and retaining high-quality human resources. Actions proposed for ***improved financing*** included ensuring that adequate financial resources were available; allocating at least 2% of national health expenditures and at least 5% of external aid for health research including capacity building; and ensuring that adequate resources were also allocated to health information and knowledge management systems.

38. Members of the Programme Subcommittee commended the Secretariat for the relevance of the document. They highlighted the need for countries to strengthen their human resource capacities and to mobilize financial resources for implementation of the Framework. Country

disparities on current stages of research development in terms of factors impacting on research activities in the health sector were underlined. Inefficient multisectoral coordination mechanisms and poor information sharing were identified as weaknesses that could impede the implementation of the Framework. New available technologies of communication were also mentioned as potential means and mechanisms to bridge the gap with remote areas in the implementation of the Framework.

39. The Programme Subcommittee made specific recommendations on the content and formulation of the document which the Secretariat agreed to incorporate for finalization of the document.

40. The Secretariat explained that the African Regional Health Observatory is expected to be a broad mechanism for monitoring the health situation and trends, and for sharing and dissemination of information products (such as data, country profiles and policy briefs). Its domain is wider than research and includes other health system issues. It was underscored that health research was part of health systems and countries should be encouraged to promote health systems research.

41. The Programme Subcommittee agreed to submit the amended document for adoption by the fifty-ninth session of the Regional Committee.

PUBLIC HEALTH, INNOVATION AND INTELLECTUAL PROPERTY: REGIONAL PERSPECTIVE TO IMPLEMENT THE GLOBAL STRATEGY AND PLAN OF ACTION (Document AFR/RC59/PSC/6)

42. The document recalled that following the adoption of the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property (GSPOA) by the World Health Assembly, the 58th Session of the WHO Regional Committee for Africa emphasized the need for ensuring synergy in the implementation of previous resolutions and decisions that were related to GSPOA. The document proposed actions for consideration by Member States.

43. In order to ***prioritise and promote research and development***, countries should map Research and Development (R and D) initiatives for health products and identify gaps and opportunities to strengthen R and D; strengthen national health information systems; prioritize public health needs and develop evidence-based research agenda; strengthen and establish networks of researchers and research institutes to promote information sharing on R and D, research results and innovation. Countries also needed to ***build and improve innovative capacity*** by strengthening health research systems, harmonizing policies and regulations, establishing and strengthening centres of excellence, building human resource capacities, and establishing linkages with regional and international scientific bodies.

44. To ***apply and manage intellectual property to contribute to innovation and promote public health***, **c**ountries should ensure better understanding of the application and management of intellectual property, revise policies, laws and regulations to effectively use public health safeguards and monitor the impact of trade agreements on access to health products. To

strengthen collaboration with international organizations and relevant stakeholders, countries needed to forge and/or strengthen collaboration with relevant organizations and stakeholders.

45. To ***enhance technology transfer,*** **c**ountries should create favourable policy and regulatory environments; invest more in science and technology; promote R and D technology transfer and strengthen capacity for production of essential medicines. To ***improve delivery and access***, countries should implement policies and regulations to strengthen supply systems, monitor and regulate medicine prices, promote competition in the pharmaceutical market, and establish and/or strengthen regulatory capacities and promote appropriate use of health products including traditional medicines.

46. To ***promote sustainable financing mechanisms***, countries should consider providing and mobilizing adequate and sustainable financing to facilitate implementation of the GSPOA. Countries should also ***establish monitoring and reporting systems*** for monitoring the implementation of GSPOA.

47. The Programme Subcommittee observed that the relationship between intellectual property, public health and innovation was a complex but necessary area for assuring access to health products. While there were different types of medicines and other commodities in circulation, some Member States were concerned about their quality and expressed their difficulties in establishing national medicine regulatory bodies. It was critical that, within countries, a core group of persons with the requisite knowledge and skills in intellectual property and pharmaceuticals be available to induce the necessary change and momentum to move this agenda forward.

48. The Programme Subcommittee called for intensification of communications in this area in order to increase awareness and the involvement of all sectors, stakeholders and communities. It also called for support from WHO and other partners in the establishment of subregional and regional centres for quality control of medicines.

49. Members of the Programme Subcommittee made specific recommendations on the content and formulation of the document which the Secretariat agreed to incorporate for finalization of the document.

50. The Secretariat informed the Programme Subcommittee that following the adoption of the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property (GSPOA) by the World Health Assembly in 2008, WHO was asked to further develop indicators and to cost the Strategy and Plan of Action. The updated Strategy and Plan of Action was adopted by the World Health Assembly in May 2009.

51. The Secretariat acknowledged that the area was complex and required support from WHO and partners and called on Member States to revise their policies and laws in order to take full advantage of the public health safeguards provided within the TRIPS agreement. The meeting was informed that regional laboratories had been identified by WHO to support Member States in quality control of medicines but so far requests from countries had been few.

52. The Secretariat informed the Subcommittee that the African Union Commission (AUC) was committed to supporting the development of traditional medicine in Africa and the local production of medicines. It was therefore important for countries to link up with the AUC and the Regional Economic Communities to pursue ongoing efforts.

53. The Programme Subcommittee agreed to submit the amended document for adoption by the Regional Committee at its fifty-ninth session.

WHO PROGRAMME BUDGET 2010-2011: ORIENTATIONS FOR IMPLEMENTATION IN THE AFRICAN REGION (Document AFR/RC59/PSC/7)

54. The document noted that in May 2009, the World Health Assembly adopted a resolution on the WHO Programme Budget 2010-2011. The resolution allowed WHO offices at all levels to formulate work plans for the biennium 2010-2011. The document described the health priorities of the African Region and gave guidance for the implementation of the WHO Programme Budget for the biennium 2010-2011.

55. An analysis of the WHO Country Cooperation Strategies had shown that strengthening health policies and systems; fighting against HIV/AIDS, tuberculosis and malaria; enhancing response to disease outbreaks and emergencies including man-made and natural disasters; improving maternal and child health; combating neglected tropical diseases; controlling the common risk factors for noncommunicable diseases; and promoting the scaling up of proven cost-effective health interventions were among the main regional health priorities.

56. Key lessons learnt in implementing previous Programme Budgets showed a steady increase in Voluntary Contributions, often earmarked, and no increase in Assessed Contributions. While the amount available from Assessed Contributions was known and could be easily allocated, the amount available from Voluntary Contributions was characterised by a high degree of uncertainty. In addition, past experience had shown that unforeseen expenditures often occurred in the implementation of the Programme Budget. As a result, there was a need to withhold a proportion of the Assessed Contributions at the beginning of the biennium as a provision for any unforeseen situations.

57. The document indicated that the Programme Budget 2010-2011 was composed of three budget segments: (i) The WHO Programmes, covering activities for which WHO had exclusive budget control; (ii) Partnerships and Collaborative Arrangements (PCA), which WHO was executing in collaboration with partners; and (iii) Outbreak and Crisis Response (OCR), covering WHO's response to natural or man-made emergencies. The approved global budget for WHO Programmes, excluding response to outbreaks and crisis, and partnerships, amounted to US$ 3 367 907 000. The African Region would receive US$ 925 684 000 representing a proportion of 27% of the WHO global budget. In terms of source of funds, US$ 209 600 000 (23%) would be provided by Assessed Contributions and US$ 716 084 000 (77%) by Voluntary Contributions.

58. Additional budget allocations to the African Region for Partnerships and Collaborative Arrangements as well as Outbreak and Crisis Response, would be funded from Voluntary Contributions. They were respectively US$ 256 430 000 and US$ 80 750 000. Thus, the overall

budget allocation for the African Region amounted to US$ 1 262 864 000, 83% of which were for Voluntary Contributions and 17% for Assessed Contributions. WHO country offices would receive 64% of regional funds, and the Regional Office including the Intercountry Support Teams would receive 36% of funds. Since the Intercountry allocations were earmarked to be spent in countries, the proportion of the total amount that would be used in countries was 81%. The balance of 19% constituted the real portion that would be spent at the Regional Office.

59. The proposed budget distribution by Strategic Objective reflected the emphasis put on communicable diseases (SO1; 34%), particularly on the global partnership and engagement towards poliomyelitis eradication. HIV/AIDS, malaria and tuberculosis (SO2) were allocated 16% of the proposed budget, representing the second highest amount. WHO Secretariat work, including strengthened presence in Member States (SO12 and 13), would receive 14% of the Programme Budget.

60. Members of the Programme Subcommittee appreciated the relevance of the information provided in the document. Concern was expressed about the 13% Programme Support Costs charged by WHO on voluntary contributions. The Programme Subcommittee requested clarifications on the criteria for budget allocation to countries, utilization of funds allocated to avian influenza and allocation of funds for the observance of commemorative health days. The Programme Subcommittee underscored the importance of giving more attention to Influenza A (H1N1), noncommunicable diseases, including risk factors, sickle cell disease, injuries and road traffic accidents, maternal and child health, and health systems strengthening. The Subcommittee noted that WHO was not a funding agency and therefore urged the Organization to focus on actions that would facilitate the implementation of country plans and strategies.

61. The Secretariat thanked members of the Programme Subcommittee for their relevant comments and contributions and noted that since the Programme Budget 2010-2011 had already been approved by the World Health Assembly, flexibility for changing the distribution of allocations was limited, hence the need to focus the discussion on the implementation of the budget.

62. With regard to distribution of budget allocations to countries, the Secretariat explained that the criteria used included needs of countries, previous experiences with budget consumption, partners' interests and WHO global validation mechanisms. Regarding the 13% Programme Support Costs, the Secretariat explained that this was established by a World Health Assembly resolution to support programme implementation costs. However, experiences over the years indicated that only 6% to 7% was recovered.

63. The Secretariat acknowledged the importance of noncommunicable diseases and informed the Programme Subcommittee of ongoing efforts for obtaining evidence-based information on noncommunicable diseases, for advocacy and for supporting countries in the development of plans and mobilization of resources. Concerning the use of funds for avian influenza, the Secretariat explained that those funds were used to strengthen surveillance systems and laboratory capacity and for training, preparedness and response.

64. The Secretariat emphasized the fact that the Programme Budget primarily covered the implementation of WHO core functions (technical cooperation; normative role; advocacy; generating and sharing information; etc.). Countries were urged to mobilize additional resources from domestic sources and other partners to address health system strengthening, maternal and child health, health promotion and noncommunicable diseases including diabetes, trauma, sickle cell anaemia, cancer, hypertension and cardiovascular diseases. The imbalance between voluntary and assessed contributions and the unpredictability of voluntary contributions were noted as real challenges for WHO. The Secretariat indicated that the forthcoming implementation of the Global Management System (GSM) would improve transparency, efficiency and effectiveness in the work of the Organization.

65. The Programme Subcommittee agreed to submit the amended document for adoption by the Regional Committee at its fifty-ninth session.

DRUG RESISTANCE RELATED TO AIDS, TUBERCULOSIS AND MALARIA: ISSUES, CHALLENGES AND THE WAY FORWARD (Document AFR/RC59/PSC/8)

66. The document recalled that the fifty-third session of the WHO Regional Committee for Africa, in 2003, had adopted a resolution on the scaling up of interventions on AIDS, tuberculosis and malaria. However, although there had been improvement in access to treatment, positive outcomes were now hampered by the development of drug resistance to HIV, TB and malaria. The main objective of the document was to propose actions to Member States with regard to prevention and control of drug resistance to AIDS, tuberculosis and malaria in the African Region.

67. The document noted that the necessity for lifelong antiretroviral therapy, coupled with HIV's high replication and mutation rates, meant that resistance would emerge even among appropriately treated and compliant patients. Recent surveys conducted at antenatal clinics in several countries in the African Region estimated that HIV resistance to all classes of medicines was less than 5%. In 2007, twenty-seven countries notified MDR-TB cases, and six countries reported at least one case of XDR-TB. Following widespread resistance to Chloroquine and sulphadoxine-pyrimethamine (SP), all malaria-endemic countries, except two in the Region, had changed their treatment policy and were using Artemisinin-based Combination Therapy (ACT). To date there was no confirmed case of resistance to ACTs in the Region.

68. The main challenges were related to the weakness of health systems including limited access to health services, poor procurement and supply management, weak laboratory infrastructure, general lack of infection control at health facility and community levels, inadequate human resources and poor logistic systems.

69. Proposed actions included the development and implementation of policies and strategies to improve access to correct diagnosis and early effective treatment; development of human resource capacity for the prevention and management of drug resistance; strengthening national and subnational health laboratory networks for drug resistance monitoring; strengthening procurement and supply of AIDS, tuberculosis and malaria medicines; setting up drug resistance and drug efficacy monitoring systems; implementing infection control measures for MDR-TB

and XDR-TB; advocating for research and development of new diagnostic tools and medicines; and mobilizing financial resources for supporting implementation of actions to prevent drug resistance in the context of health systems strengthening.

70. Members of the Programme Subcommittee commended the Secretariat for the quality of the document. They highlighted the need for countries to strengthen their laboratory capacities for drug resistance prevention and control, reinforce human resource capacities, strengthen medicines procurement, supply and management systems, and promote patient compliance as key interventions for prevention and control of drug resistance. It was also emphasized that countries needed to prioritize the proposed actions taking into account country realities.

71. Delegates shared country experiences of cases of new infections with HIV strains resistant to first-line drugs and their negative impact on affordability of second-line medicines and case management. The need to reinforce laws to prevent proliferation of counterfeit medicines was underlined.

72. The Members of the Programme Subcommittee expressed concern about the emergence of malaria resistance to ACT in East and Southern Asia. They observed that over-diagnosis of malaria was a significant issue and called for more evidence in order to improve case management in countries. Concern was also expressed about local preparations of some medicines based on traditional formulations that lead to suboptimal doses. The need to focus on syndromic management of malaria, taking into account the weak capacity for laboratory diagnosis, particularly in remote areas, until rapid diagnostic tests were available, was emphasized.

73. Concerning drug resistance to tuberculosis, the weakness of laboratory capacity for diagnosis of MDR-TB and XDR-TB was highlighted. A suggestion was made for the expansion of infection control actions to cover not only MDR-TB and XDR-TB but other diseases as well.

74. The Secretariat acknowledged the relevance of comments made by the Members of the Programme Subcommittee and agreed to incorporate the suggestions. They requested countries to share the evidence available on new infections with HIV strains resistant to first-line drugs as well as on the utilization of traditional formulations for malaria treatment. The Secretariat informed the meeting that technical support for generating the necessary evidence would be made available on request.

75. With regards to the threat of emergence of ACT resistance in South-East Asia, the Secretariat informed members of the Programme Subcommittee that WHO, with the collaboration of affected countries and partners, was supporting the implementation of a containment strategy.

76. The Programme Subcommittee agreed to submit the amended document and prepared a draft resolution (AFR/RC59/PSC/WP/1) for adoption by the fifty-ninth session of the Regional Committee.

ACCELERATED MALARIA CONTROL: TOWARDS ELIMINATION IN THE AFRICAN REGION (Document AFR/RC59/PSC/9)

77. The document recalled that the African Region accounted for 86% of malaria episodes and 91% of malaria deaths worldwide. Reference was made to commitment to malaria control which culminated in the UN Secretary-General's call for universal coverage of malaria control interventions for all people at risk of malaria by 2010.

78. The document noted that with high coverage of comprehensive package of malaria prevention and control interventions, a rapid decline in malaria burden was possible as had been shown in Botswana, Eritrea, Ethiopia, Kenya, Rwanda, Sao Tome and Principe, South Africa and Swaziland. Advancing from malaria control (i.e. a reduction of the disease burden to a level where it is no longer a public health problem) to malaria elimination (interruption of local mosquito-borne malaria transmission) should be seen as a continuum.

79. Challenges that countries needed to address include lack of comprehensive policies and strategies; delays between policy adoption and implementation; quality implementation of interventions; inadequate human resource capacity; and weak health systems which negatively influenced programme performance. Inadequate harmonization and alignment by partners, resource mobilization and utilization adversely affected the scaling up of interventions.

80. The document noted the need for countries in stable transmission areas to have a consolidation phase before introducing a STEPwise programme reorientation to pre-elimination, and then to elimination, and prevention of reintroduction of malaria transmission.

81. Proposed actions included updating policies and strategic plans; strengthening national malaria control programmes; improving procurement and supply of antimalarial commodities; accelerating the delivery of proven interventions for universal coverage and impact; consolidating control in endemic countries; strengthening surveillance, monitoring and evaluation; advancing from control to pre-elimination and elimination when appropriate; improving coordination and alignment of all partners; mobilizing adequate resources; and strengthening research.

82. Members of the Programme Subcommittee commended the Secretariat on the quality and relevance of the document. It was noted that the document was silent on Affordable Medicine Facility for Malaria (AMFm). There were concerns about the risk of adopting a vertical approach and it was recommended that programme integration during implementation be strongly reflected in the document. The need for strengthening human and laboratory capacity as well as scaling up interventions was highlighted. There was a call for countries to take into account the current level of implementation and achievements before contemplating programme transitions towards control, consolidation and elimination.

83. The risk of over-diagnosis of malaria within the context of improper application of the syndromic approach was discussed and the need to reflect presumptive therapy in the treatment guidelines at peripheral levels for young children was recommended. The application of synergistic methods for integrated vector management was highlighted. The importance of

community-based approaches, social mobilisation and the role of behavioural research in scaling up the use of cost-effective interventions was noted. The Programme Subcommittee sought clarifications on intermittent preventive therapy in infants (IPTi), intermittent preventive therapy in children (IPTc) and the current status of the use of DDT in malaria vector control.

84. In response, the Secretariat explained that the purpose of the document was to sensitize countries on the urgency to scale up malaria control interventions based on progress in some countries, and to stimulate response to the growing global interest and funding opportunities. The need to ensure country ownership and coordination was also emphasized. Policy guidance on IPTc and IPTi would be based on technical expert consultation after a full review of research results, taking into account issues of safety, cost-effectiveness and feasibility in specific epidemiological settings.

85. The Secretariat indicated that WHO would, in collaboration with the Roll Back Malaria Partnership, continue to provide technical support to countries during Phase 1 of the Affordable Medicines Facility for Malaria (AMFm). The Secretariat also noted that DDT remained recognized as an effective insecticide for vector control. The importance of keeping preventive treatment and syndromic approaches to case management in the relevant guidelines and tools was reiterated. The Secretariat stressed the importance of strong country stewardship and coordination of all stakeholders including partners to improve programme planning, implementation, monitoring and evaluation. Furthermore, the Secretariat underscored the need for Member States to strengthen their national malaria control programmes including having in place core human resources to cover all the key strategic areas of malaria control at central and decentralized levels. The need for efficient mechanisms and structures to ensure programme performance, transparency and accountability in accordance with the “Three Ones” principle was emphasized.

86. The Secretariat agreed to amend the document in order to reflect the recommendations of the Programme Subcommittee.

87. The Programme Subcommittee agreed to submit the amended document and prepared a draft resolution (AFR/RC59/PSC/WP/2) for adoption by the fifty-ninth session of the Regional Committee.

TACKLING NEGLECTED TROPICAL DISEASES IN THE AFRICAN REGION
(Document AFR/RC59/PSC/10)

88. The document indicated that the regional Neglected Tropical Diseases (NTD) programme had prioritized nine bacterial and parasitic diseases. One disease (Guinea worm) was targeted for eradication, four diseases (leprosy, lymphatic filariasis, onchocerciasis, human African trypanosomiasis) were targeted for elimination while three diseases (schistosomiasis, Buruli ulcer, yaws) were targeted for control. It was estimated that NTDs affected one billion people in the world, with Africa accounting for up to 90% of the total disease burden.

89. The prevalence of lymphatic filariasis had been reduced following the provision of preventive chemotherapy for more than 53 million people in the Region through the community-

directed treatment strategy. The prevalence of Guinea worm disease had decreased from 3.5 million cases in 1985 to 3770 cases in 2007. Leprosy had been eliminated at national level in all the 46 Member States as at the end of 2007.

90. Despite these significant achievements, the Region still faced challenges such as low coverage of interventions, especially in rural areas that were not easily accessible, inadequate promotion of integrated implementation of disease-specific interventions and co-implementation of activities with other community-based interventions, non-availability of appropriate medicines, inadequate numbers of skilled human resources, and inadequate financial resources.

91. Proposed actions included strengthening health systems, strengthening leadership and ownership, streamlining and strengthening national systems for management of medicines, reinforcing supportive activities, intensifying interventions for eradication of Guinea worm disease, reorganizing and strengthening surveillance, monitoring and evaluation, working with partners to scale up operational and clinical research, organizing joint advocacy visits to countries and developing effective strategies for advocacy.

92. Members of the Programme Subcommittee welcomed the document, given the negative impact of NTDs on vulnerable groups. They sought clarifications on the definition of NTDs used in the document and called for emphasis to be put on poverty reduction, and reduction/elimination of stigmatization among marginalized groups such as pygmies, as a way of addressing the NTD disease burden. The Programme Subcommitte also observed that there was need to strengthen intercountry and cross-border collaboration when implementing the various NTD interventions. The Programme Subcommitte recognized the importance of involving regional economic communities in the NTD interventions.

93. In regard to the actions proposed, the members of the Programme Subcommittee felt that health systems strengthening should be the main action to be undertaken by Member States and that the other actions should then follow. Increased community participation in NTD interventions was advised. The Programme Subcommittee suggested the strengthening of routine surveillance systems for all NTDs. Member States were requested to promote research on new therapies and strategies as the existing therapies were in some cases associated with serious adverse effects.

94. The Secretariat thanked the Programme Subcommittee for the interest shown in the document and underscored the need for Programme Subcommittee members to advocate with their governments on the need to prioritize NTDs in the health agenda. It was indicated that the proposed definition would be revisited in order to include all key elements. The Secretariat indicated that the document would be revised to accommodate the contributions from the Programme Subcommittee.

95. The Programme Subcommittee agreed to submit the amended document for adoption by the Regional Committee at its fifty-ninth session.

POLICY ORIENTATIONS ON THE ESTABLISHMENT OF CENTRES OF EXCELLENCE FOR DISEASE SURVEILLANCE, PUBLIC HEALTH LABORATORIES, FOOD AND MEDICINES REGULATION
(Document AFR/RC59/PSC/11)

96. The document defined Centres of Excellence for Disease Surveillance and Control (CEDSC) as *"a network of health facilities selected to support disease surveillance, laboratory and food and medicines regulatory services"*. These facilities were selected on the basis of a set of criteria such as experience, outcomes, quality, efficiency and effectiveness. The overall goal of the CEDSC is to support ongoing efforts aimed at strengthening national core capacity in disease surveillance including International Health Regulations, public health laboratory services and food and medicines regulation through enhanced collaboration and cooperation within and between Member States.

97. The absence of a national policy and legal framework to guide the formation of CEDSC and weak health systems were major barriers to the establishment of these centres and the subsequent provision of quality disease surveillance as well as laboratory, food and medicines regulatory services. The majority of Member States had limited or no capacity to control and regulate importation of food and medicines, leading to proliferation of the sale of poor quality medicines and food products on the open market.

98. Proposed actions included conducting an assessment of available national capacities, developing comprehensive national policies and legal frameworks on CEDSC, undertaking advocacy with relevant departments and ministries on the need to create an integrated CEDSC, developing national implementation plans, monitoring and evaluation, and ensuring financing and sustainability of Centres.

99. Members of the Programme Subcommittee welcomed the proposed orientations for the establishment of Centres of Excellence. They stressed that all countries would not have the capacity to develop their own Centres of Excellence and underscored the need for collaboration among Member States, especially at subregional level, in this area. The role of regional economic communities in these efforts was deemed critical.

100. Clarifications were sought on the type of Centres of Excellence that was being proposed given the current situation where the various functions related to disease surveillance, public health laboratories, and food and medicines regulation were being performed by institutions that were based in different sectors and were operating under different regulatory bodies. Members of the Programme Subcommittee endorsed the need to conduct initial assessments of core capacities and competencies to inform the establishment of Centres of Excellence. They encouraged Member States and WHO to share the findings from the assessments. The process of establishing these Centres should include strengthening the existing institutional, human, financial, technical and logistical capacities.

101. Members of the Programme Subcommittee called upon WHO to undertake advocacy with national authorities to facilitate the integration of various health research and surveillance functions that may exist under different structures in various ministries. The issue of integrating

food and medicines regulation with disease surveillance and public health laboratories was raised and suggestions were made to separate these functions.

102. In response, the Secretariat emphasized that the establishment of Centres of Excellence was a very important initiative covering priority areas that would help address the burden of communicable diseases, early detection and response to epidemics, and quality control of food and medicines. It was clarified that the purpose was not to develop capacities in all areas in one location, but to build on existing capacities, maximize complementarity depending on the epidemiological context, and improve functionality through effective networking.

103. The Secretariat recalled that the 2008 Algiers Declaration on Health Research requested WHO to "support the establishment of subregional and regional centres of excellence to develop research for health". This was also reflected in the 2008 Bamako Call to Action on Health Research. To this end, the Secretariat had made initial contacts with some countries. The need for Member States to prioritize research, invest more in human resources capacity and technologies and mobilize additional resources for research was emphasized.

104. The Programme Subcommittee agreed to submit the amended document and prepared a draft resolution (AFR/RC59/PSC/WP/3) on the subject for adoption by the Regional Committee at its fifty-ninth session.

STRENGTHENING OUTBREAK PREPAREDNESS AND RESPONSE IN THE AFRICAN REGION IN THE CONTEXT OF THE CURRENT INFLUENZA PANDEMIC
(Document AFR/RC59/PSC/12)

105. The document noted that the current rapid human-to-human transmission of the newly emerged influenza A (H1N1) virus, coupled with its spread to 41 countries within a month, had raised concern that the next influenza pandemic might be imminent. As of 20 May 2009, 10 587 confirmed cases with 84 deaths had been reported globally. Nine countries in the African Region (Benin, Democratic Republic of Congo, Ghana, Kenya, Nigeria, Seychelles, South Africa, Tanzania, and Uganda) had reported suspected cases although these had not been confirmed in the laboratory.

106. As part of the WHO global response, the Regional Office for Africa had established crisis management committees at the Regional Office, in Intercountry Support Teams and country offices. In addition, WHO had despatched over a million treatment doses of oseltamivir, an antiviral medicine, and personal protective equipment (PPE) to all countries in the Region. Member States in the Region had responded to the threat of a pandemic by reactivating their Epidemic Management Committees and were updating their Preparedness and Response Plans. At both the fourth session of the African Union Conference of Ministers of Health, and the Extraordinary Meeting of the Health Ministers of the Economic Community of Central African States held in Kinshasa from 9 to 11 May 2009, Member States had reaffirmed their commitment to mobilize the resources needed to mitigate the potential impact of an influenza pandemic in Africa.

107. The main issues and challenges that Member States needed to address were: the potential negative impacts of pandemic influenza on populations and on health systems in the African Region; limited public awareness of health issues; inadequate planning and preparedness; limited surveillance, situation monitoring and assessment systems, including lack of full implementation of

the International Health Regulations (2005); limited laboratory capacity; inadequate coordination of response activities; inadequate infection control in health care settings and in communities; and inadequate resource mobilization and allocation.

108. The proposed actions to enable Member States to prepare for, and mitigate the effects of, a potential influenza pandemic included mitigating the potential impact on populations and health systems; improving public awareness of health issues; strengthening planning and preparedness; scaling up all components of surveillance, situation monitoring and assessment systems; addressing the limited laboratory capacities for detection; ensuring effective coordination of response activities; strengthening infection control in health care settings and in the community; and improving mechanisms for resource mobilization and allocation.

109. Members of the Programme Subcommittee commended the Secretariat for the importance of the document and congratulated WHO for the leadership shown through advocacy; sharing of accurate and up-to-date information on the evolving situation; provision of technical guidelines; and provision of initial stocks of oseltamivir (Tamiflu) during the current potential pandemic.

110. Experiences on measures that had been taken by countries to prepare and respond to the potential pandemic were shared. Concerns were raised about the level of awareness, availability of specific funds to implement the updated national preparedness and response plans, availability of sufficient supplies of oseltamivir, availability of paediatric formulations, availability of case management guidelines, and the potential development of oseltamivir resistance due to misuse and counterfeit medicines.

111. The Programme Subcommittee members emphasized the need to ensure high-level political involvement for multisectoral, intercountry and subregional collaboration and coordination, improvement in the provision of safe water and sanitation and enhancement of public awareness. High-level political involvement would also facilitate the availability of increased resources and fund-raising, including the creation of an African fund generated by Member States for the management of epidemics. The need to strengthen surveillance, research and laboratory capacity, and to organize simulation exercises as part of epidemic preparedness and response was reiterated. The members also expressed the need for countries to maintain alertness and preparedness in between epidemics and pandemics.

112. The Secretariat acknowledged the comments made by the members of the Programme Subcommittee and agreed to use the proposed suggestions to enrich the document. The Secretariat reminded the meeting that the African Union had discussed this matter and a communiqué on the subject had been issued by the fourth ordinary session of the African Union Conference of Ministers of Health. Although no funds had been received for the prevention and control of the ongoing epidemic, efforts were under way to mobilize resources from pledges made globally. It was emphasized that any funds made available by WHO would be catalytic, and countries should intensify their efforts to raise additional financial resources.

113. The Programme Subcommittee agreed to submit the amended document and prepared a draft resolution (AFR/RC59/PSC/WP/4) on the subject for adoption by the Regional Committee at its fifty-ninth session.

TERMS OF REFERENCE OF THE MEETING OF AFRICAN REGION DELEGATIONS TO THE WORLD HEALTH ASSEMBLY AND THE EXECUTIVE BOARD (Document AFR/RC59/PSC/13)

114. The document recalled the implementation of the Terms of Reference of the Meeting of the African Region Delegations to the World Health Assembly and the Executive Board.

115. The document noted the need to strengthen coordination between the WHO Regional Office for Africa, the African Group in Geneva and the African Union with regard to the participation of Delegations of the African Region in the World Health Assembly and the Executive Board. The importance of speaking with one voice on behalf of Africa and improving the quality of interventions during global health debates was emphasized.

116. The fourth ordinary session of the African Union Conference of Ministers of Health, held in Addis Ababa, in May 2009, had recommended that the allocation of tasks to Member States speaking on behalf of Africa during the World Health Assembly should be done in accordance with the AU rules and regulations. The current document discusses the issue of coordination and revisits document AFR/RC57/INF.DOC/5 giving the task of assigning responsibilities on selected agenda items of the World Health Assembly and Executive Board to the African Group Coordinator in consultation with the African Union. Accordingly, paragraphs 2.1 and 3.1 of the document had to be revisited to reflect the recommendations made by the AU.

117. Members of the Programme Subcommittee, recognizing WHO's primary role as the leading agency in health, proposed to amend sections 2.1 and 3.1 to reflect this coordinating role during the deliberations of the Health Assembly and the Executive Board. It was also noted that there was a tendency for other African countries to take the floor even before the country designated for the selected agenda items. There was a need to have this situation rectified. Concerns were also raised on the realistic nature of the timelines proposed in the document, and clarifications were sought on the mechanisms for addressing, in a coordinated manner, late contributions from Member States.

118. The Secretariat thanked members of the Subcommittee for the comments and inputs and noted that it was important to differentiate between WHO's technical role and the AU's political mandate. Concerning the timelines, the Secretariat said that the proposals were feasible.

119. In order to ensure that the designated country spoke before other African Member States, the Secretariat assured the Programme Subcommittee that a list of the designated countries would be submitted to the Chairman of the sessions of the World Health Assembly and Executive Board meetings. New subjects and emergency situations would be addressed during coordination meetings organised during the World Health Assembly and the Executive Board sessions.

120. The Programme Subcommittee agreed to submit the amended document on the subject for adoption by the Regional Committee at its fifty-ninth session.

TOWARDS THE ELIMINATION OF MEASLES IN THE AFRICAN REGION BY 2020
(Document AFR/RC59/PSC/14)

121. The document noted that reduction in measles mortality contributed significantly towards attaining the Millennium Development Goal 4 (MDG 4), and that routine measles immunization coverage was a key indicator for measuring progress towards attainment of this goal. Implementation of the measles mortality reduction strategies in the African Region had led to 89% reduction in estimated measles deaths between 2000 and 2007. This was largely due to improvements in routine immunization coverage and the vaccination of 396 million children through measles Supplemental Immunization Activities (SIAs) between 2001 and 2008. The crucial role of the Measles Initiative in helping to mobilize financial resources and provide technical support to the African Region was acknowledged.

122. Following the successes, the African Regional Measles Technical Advisory Group had proposed the adoption of measles pre-elimination targets as a step toward measles elimination. Measles elimination is defined as the absence of endemic measles cases for a period of twelve months or more, in the presence of adequate surveillance, and when the following criteria were met: achieving and maintaining at least 95% coverage with both first dose measles vaccination and the second opportunity of measles vaccination in all districts and at the national level; having less than 10 confirmed cases in 80% or more of measles outbreaks; and achieving a measles incidence of less than 1 confirmed case per million inhabitants per year.

123. The key challenges to measles elimination in the African Region included the continued high incidence and large-scale outbreaks in some countries, the need for continued commitment by Member States, inadequate access to and quality of immunization services, suboptimal surveillance performance and quality of immunization monitoring data.

124. Actions proposed included strengthening immunization systems; attaining high coverage in routine immunization and Supplemental Immunization Activities; addressing the surveillance and data quality gaps; sustaining national ownership and community participation; and setting a goal for measles elimination by the year 2020. The document requested partners to continue their support to Member States in mobilizing the resources necessary to achieve measles elimination.

125. Members of the Programme Subcommittee commended the Secretariat for including this timely and pertinent document in the agenda of the meeting. They recognized the considerable progress made in increasing immunization coverage and reducing measles mortality in the Region. Although countries were at different stages of measles control, members of the Programme Subcommittee felt that this should not be a hindrance to setting the elimination goal.

126. Concerns were raised about the pockets of low coverage, inaccessibility of some geographic areas, gaps in the cold chain system, recent reports of large-scale measles outbreaks in some countries, and the recent change in the epidemiological pattern of measles with a large proportion of older children and adults being affected. Members of the Programme Subcommittee indicated that it was necessary to strengthen health systems and mobilize additional resources in order to raise immunization coverage beyond 85%. They also highlighted

country experiences showing that integrating activities (especially SIAs) as a package would help to improve the cost-effectiveness and impact of interventions.

127. The Secretariat thanked the members of the Programme Subcommittee for their contributions. The Secretariat advocated for the African Region to adopt the elimination goal with the support of international and local partners. In May 2009, the WHO Executive Board had discussed a paper on global measles elimination, assessing progress in all regions. At global level, the feasibility of global elimination of measles (cost-effectiveness, role of routine immunization, health systems) was being studied and the results would be presented to the Executive Board in 2010. In this context, the discussion of an African regional elimination goal would position the Region within the global perspective of elimination. Although challenges to reaching this goal in the African Region remained as regards logistics, finance, health systems and others, Members of the Programme Subcommittee acknowledged the significant successes in measles control in the last few years.

128. The Programme Subcommittee agreed to submit the amended document for adoption by the Regional Committee at its fifty-ninth session.

ADOPTION OF THE REPORT OF THE PROGRAMME SUBCOMMITTEE INCLUDING THE DRAFT RESOLUTIONS (Document AFR/RC59/PSC/15)

129. After review, discussions and amendments, the Programme Subcommittee adopted the report, and four draft resolutions, for submission to the fifty-ninth session of the Regional Committee in August 2009. The draft resolutions, contained in Section II of this report, were on: (a) Drug resistance related to AIDS, tuberculosis and malaria: issues, challenges and the way forward (AFR/RC59/WP/1); (b) Accelerated malaria control: towards elimination in the African Region (AFR/RC59/WP/2); (c) Policy orientations on the establishment of centres of excellence for disease surveillance, public health laboratories, food and medicines regulation (AFR/RC59/WP/3); and (d) Strengthening outbreak preparedness and response in the African Region in the context of the current influenza pandemic (AFR/RC59/WP/4).

ASSIGNMENT OF RESPONSIBILITIES FOR THE PRESENTATION OF THE REPORT OF THE PROGRAMME SUBCOMMITTEE TO THE REGIONAL COMMITTEE

130. The Programme Subcommittee decided that the Chairman or Vice-Chairman would present the report of its meeting to the Regional Committee.

CLOSURE OF THE MEETING

131. The Regional Director thanked the Government of Gabon for its hospitality that had contributed immensely to achieving the objectives of the meeting. He also thanked members of the Programme Subcommittee for their active participation in the meeting and their excellent inputs. He stated that members of the Programme Subcommittee had extensively reviewed and provided comments on the technical documents that would be submitted to the fifty-ninth session of the Regional Committee scheduled for Kigali, Rwanda, in August 2009. The Regional

Director went on to thank the Secretariat, the interpreters and all the support staff for their contributions to the success of the meeting.

132. The honourable Minister of Public Health and Hygiene of Gabon, Mr Idriss Ngari who attended the closure of the meeting on behalf of the Government of Gabon, thanked WHO for the opportunity to host the meeting. He also thanked members of the Programme Subcommittee and commended the Regional Director for his commitment to ensuring the success of the work of the Regional Committee. He then wished the participants a safe journey back to their various countries.

133. The Chairman informed the meeting that the term of office on the Programme Subcommittee of Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo and Côte d'Ivoire had come to an end. He thanked them for their valuable contribution to the work of the Subcommittee. They would be replaced by Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Guinea-Bissau, Liberia, Mauritius, Mozambique and Namibia.

134. The Chairman thanked the members of the Programme Subcommittee for their active participation in the deliberations. He also thanked the Regional Director and other members of the Secretariat for the good quality of the documents and for their contribution to the success of the meeting.

135. The Chairman then declared the meeting closed.

SECTION II

DRAFT RESOLUTIONS

The Programme Subcommittee considered and proposed amendments to the following drafts resolutions on: (a) Drug resistance related to AIDS, tuberculosis and malaria: issues, challenges and the way forward (AFR/RC59/WP/1); (b) Accelerated malaria control: towards elimination in the African Region (AFR/RC59/WP/2); (c) Policy orientations on the establishment of centres of excellence for disease surveillance, public health laboratories, food and medicines regulation (AFR/RC59/WP/3); and (d) Strengthening outbreak preparedness and response in the African Region in the context of the current influenza pandemic (AFR/RC59/WP/4).

AFR/RC59/WP/1: DRUG RESISTANCE RELATED TO AIDS, TUBERCULOSIS AND MALARIA: ISSUES, CHALLENGES AND THE WAY FORWARD

(Document RC59/PSC/8)

The Regional Committee,

Having examined the document entitled “Drug resistance related to AIDS, tuberculosis and malaria: issues, challenges and the way forward”;

Aware that good laboratory services are essential for confirming diagnosis, monitoring treatment outcomes and guiding decisions to change to second line treatment;

Bearing in mind that combination therapy as a mechanism for prolonging the useful therapeutic life of HIV, TB and malaria medicines is recommended as one of the approaches to prevent development of drug resistance;

Aware that there has been an increase in financial resources for the control of HIV, TB and malaria, but noting that these resources have not been readily used for drug resistance monitoring;

Concerned that the many health system challenges like access to health services, procurement and supply management, laboratory infrastructure, human resources and logistics could contribute to the widespread development of drug resistance to HIV, TB and malaria;

Recalling Resolution AFR/RC53/R6 on scaling up interventions against HIV/AIDS, tuberculosis and malaria in the African Region (2003);

Encouraged by measures already taken to build capacity for monitoring drug resistance and to develop and implement new treatment guidelines;

1. ENDORSES the document entitled “Drug resistance related to AIDS, tuberculosis and malaria: issues, challenges and the way forward”;

2. REQUESTS partners to increase both financial and technical support to countries to facilitate the implementation of efforts for prevention and control of AIDS, tuberculosis and malaria drug resistance;

3. URGES Member States:

(a) to develop and implement policies and strategies to improve access to correct diagnosis and early effective treatment;

(b) to strengthen national and subnational health laboratory networks, including human resources capacity;

(c) to strengthen procurement and the management of HIV/AIDS, tuberculosis and malaria medicines and supplies;

(d) to set up drug resistance and drug efficacy monitoring systems;

(e) to implement administrative, environmental, personal protection and integrated infection control measures particularly for multidrug-resistant and extensively drug-resistant TB;

(f) to mobilize financial resources for supporting implementation of these actions in the context of health system strengthening;

4. REQUESTS the Regional Director:

(a) to provide technical support to Member States to develop and implement action plans for prevention and control of AIDS, tuberculosis and malaria drug resistance as well as subregional networks for drug resistance monitoring as part of strengthening disease surveillance systems;

(b) to advocate for more resources and long-term international support for implementation of interventions for prevention and control of AIDS, tuberculosis and malaria drug resistance;

(c) to monitor and report to the sixty-first session of the Regional Committee and thereafter every year on progress in implementing interventions for prevention and control of AIDS, tuberculosis and malaria drug resistance.

AFR/RC59/WP/2 ACCELERATED MALARIA CONTROL: TOWARDS ELIMINATION IN THE AFRICAN REGION (Document RC59/PSC/9)

The Regional Committee,

Having examined the document entitled “Acceleration of malaria control: towards elimination in the African Region”;

Recalling Regional Committee resolution AFR/RC50/R6 on Roll Back Malaria in the African Region: a framework for implementation; the 2000 and 2006 Abuja OAU and AU Summits Commitments on HIV and AIDS, tuberculosis and malaria; resolution AFR/RC53/R6 on scaling-up interventions against HIV/AIDS, tuberculosis and malaria; resolutions WHA58.2 and WHA60.18 on malaria control and establishment of Malaria Day and the UN Secretary General’s 2008 Malaria Initiative which called for universal access to essential malaria prevention and control interventions;

Aware of the persisting heavy burden of Malaria in the African Region and its devastating consequences on health and socio-economic development;

Recognizing that the lack of evidence-based policies, comprehensive strategies, delays in implementation, weak health systems and inadequate human resource capacity negatively influence programme performance;

Mindful of the fact that coordination and harmonization of partner activity for resource mobilization and efficient utilization are critical for national and regional performance in malaria control;

Aware that scaling up cost-effective interventions [Long Lasting Insecticidal Nets (LLINs), Indoor Residual Spraying (IRS), Intermittent preventive Treatment of malaria in pregnancy (IPTp), Artemisimin-based combination therapies (ACTs)] for universal coverage results in a critical reduction of the malaria burden and that malaria control currently relies on a limited number of tools;

Acknowledging the invaluable support received from multilateral and bilateral cooperation partners, foundations, malaria advocates and community-based organizations;

Analyzing the new opportunities raised at the international level to control and eliminate malaria [the UN, AU, World Economic Forum, GFATM, Affordable Medicines Facility for malaria (AMFm), the World Bank Booster Programme, the US President's Malaria Initiative (US/PMI), the Bill and Melinda Gates Foundation];

1. ENDORSES the document entitled 'Accelerated malaria control: towards elimination in the African Region';

2. URGES Member States:

(a) to integrate malaria control in all poverty reduction strategies and national health and development plans in line with the commitments of UN, AU and Regional Economic Communities (RECs) and mobilize local resources for sustainable implementation and assessment of the impact of accelerated malaria control;

(b) to support health systems strengthening including building of human resource capacity through pre- and in-service training for the scale-up of essential malaria prevention and control interventions;

(c) to support ongoing research and development initiatives for new medicines, insecticides, diagnostic tools and other technologies for malaria control and elimination and invest in operational research for informed policy and decision making in order to scale-up and improve programme efficiency for impact;

(d) to strengthen the institutional capacity of national malaria programmes at central and decentralized levels for better coordination of all stakeholders and partners in order to ensure programme performance, transparency and accountability in accordance with the principle of the 'Three Ones';

(e) to lead joint programme reviews, develop comprehensive needs-based and fully budgeted strategic and operational plans with strong surveillance, monitoring and evaluation components;

(f) to strengthen health information systems, integrated disease surveillance and response and undertake appropriate surveys in order to generate reliable evidence, facilitate

translation of knowledge into successful implementation and inform programmatic transitions;

(g) to invest in health promotion, community education and participation, sanitation, and increase human resource capacity with emphasis on mid-level and community health workers for universal coverage of essential interventions using integrated approaches;

(h) to ensure rigorous quantification, forecasting, procurement, supply and rational use of affordable, safe, quality-assured drugs and commodities for timely and reliable malaria diagnosis and treatment at health facility and community levels;

3. REQUESTS partners involved in supporting malaria control efforts in the Region to increase funding for malaria control in order to reach the UN targets of universal coverage, reducing malaria deaths to minimal levels, and achieving health-related Millennium Development Goals to which malaria control contributes;

4. REQUESTS the Regional Director:

(a) to facilitate high-level advocacy, coordination of partner action in collaboration with the UN, RBM, other partner institutions, the AU and regional economic communities for adequate resource mobilization and efficient technical cooperation;

(b) to support the development of new tools, medicines, applied technologies and commodities and help revitalize drug and insecticide efficacy monitoring networks;

(c) to report to the sixty-first session of the Regional Committee, and thereafter every other year, on the progress made in the implementation of accelerated malaria control in the African Region.

AFR/RC59/WP/3 POLICY ORIENTATIONS ON THE ESTABLISHMENT OF CENTRES OF EXCELLENCE FOR DISEASE SURVEILLANCE, PUBLIC HEALTH LABORATORIES, FOOD AND MEDICINES REGULATION

(Document AFR/RC59/PSC/11)

The Regional Committee,

Having carefully examined the technical paper on policy orientations on the establishment of centres of excellence for disease surveillance, public health laboratories and food and medicines regulation;

Aware of the magnitude of the burden of communicable and noncommunicable diseases and the negative social and economic consequences in the African Region;

Deeply concerned about the status of communicable and noncommunicable disease surveillance in the African Region;

Noting that a significant number of Member States have limited capacities for effective and comprehensive disease surveillance and response, laboratory investigation, and food and medicines regulation;

Recalling resolutions AFR/RC48/R2 on integrated disease surveillance; AFR/RC58/R2 on strengthening public health laboratories; WHA58.3 on revision of the International Health Regulations and WHA 61.2 on implementation of the International Health Regulations (2005);

Mindful of the Algiers Declaration and the Bamako Call to Action urging the establishment of centers of excellence for research;

Appreciating the commitment and efforts made so far by Member States and partners to implement integrated epidemiological surveillance of diseases, their strategy for responding to the latter and their quest for better surveillance, control, elimination or eradication and response;

Convinced that the establishment of a network of reference centres for diseases surveillance, laboratory investigation and food and medicines regulation will ultimately contribute to a reduced disease burden, attainment of the health-related MDGs and improved quality of life of communities in the Region;

1. APPROVES the proposed actions aimed at strengthening disease surveillance, public health laboratories, and food and medicines regulation through the establishment of centres of excellence by Member States;

2. URGES Member Sates:

(a) to conduct an assessment of existing infrastructure and human capacity as the initial step in determining whether or not the country is ready to set up a centre of excellence for disease surveillance, public health laboratories, and food and medicines regulation;

(b) with the necessary resources to develop a national policy framework on centres of excellence for disease surveillance, public health laboratories, and food and medicines regulation, that will guide the establishment of these centres;

(c) to sensitize other national departments and ministries to the need to create centres of excellence for disease surveillance, public health laboratories, and food and medicines regulation;

(d) planning to establish these centres to strengthen monitoring and evaluation systems that will enable countries to set targets and develop measurable indicators to ensure the delivery of quality services related to centres of excellence for disease surveillance, public health laboratories, and food and medicines regulation;

(e) to secure multiple sources of funding for centres of excellence in order to guarantee sustained performance;

3. REQUESTS the Regional Director:

(a) to provide technical support to Member States for the development of national frameworks, implementation plans and monitoring and evaluation tools for centres of excellence for disease surveillance, public health laboratories, and food and medicines regulation;

(b) to provide technical support for the establishment of a regional network of centres of excellence that will act as reference facilities for disease surveillance, public health

laboratories, and food and medicines regulation in the African Region and, with time, become WHO collaborating centres;

(c) to advocate for additional resources at national and international levels for the establishment of centres of excellence for disease surveillance, public health laboratories, and food and medicines regulation;

(d) to report to the Sixty-first Regional Committee, and every other year thereafter, on the progress made in the establishment of centres of excellence for disease surveillance, public health laboratories, and food and medicines regulation.

AFR/RC59/WP/4 STRENGTHENING OUTBREAK PREPAREDNESS AND RESPONSE IN THE AFRICAN REGION IN THE CONTEXT OF THE CURRENT INFLUENZA PANDEMIC (Document AFR/RC59/PSC/12)

The Regional Committee,

Having carefully examined the technical paper on strengthening outbreak preparedness and response in the African Region in the context of the current influenza pandemic;

Aware that national health systems are overburdened and lack adequate human, financial and preparedness capacity to respond to a potential pandemic;

Deeply concerned that the continued international spread of the newly emerged influenza A (H1N1) may potentially result in a humanitarian, social and economic burden on Member States;

Concerned about the potential impact of pandemic influenza on vulnerable populations in the African Region who are already suffering from multiple diseases and conditions;

Acknowledging the high level of commitment of Member States to prevention and control of epidemic- and pandemic-prone diseases;

Noting the communiqué on the new influenza A (H1N1) issued by the fourth session of the African Union Conference of Ministers of Health held in Addis Ababa from 4 to 8 May 2009;

Reaffirming our commitment to implementing resolutions AFR/RC48/R2 on integrated disease surveillance; AFR/RC56/R7 on preparedness and response to the threat of an avian influenza pandemic; AFR/RC58/R2 on strengthening public health laboratories; and WHA61.2 on implementation of the International Health Regulations (2005);

1. ENDORSES the technical paper and approves the proposed actions aimed at strengthening the capacity of Member States to prepare for and respond to epidemics and pandemics;

2. URGES Member States:

(a) to implement communication strategies that regularly provide up-to-date information to all levels of the community regarding what is known about circulating epidemic- and

pandemic-prone diseases, appropriate home-based care and protective measures people can take to reduce the risk of infection;

(b) to ensure the highest level of government support in addressing the new influenza A (H1N1) threat;

(c) to reduce the potential impact of epidemic- and pandemic-prone diseases on populations by ensuring uninterrupted provision of health care services, maintaining adequate treatment supplies and implementing basic infection control measures to protect health care staff and patients;

(d) to strengthen the capacity of health services to reduce disease transmission in health care facilities by ensuring regular water supplies and sanitation and by assuring access to hand-hygiene facilities with water and soap at all levels;

(e) to continue integrated disease surveillance and expand it to all levels including the community and implement the International Health Regulations (2005) within the framework of integrated surveillance;

(f) to strengthen capacity for influenza diagnosis by providing sufficient material and financial resources to support public health laboratory functions;

(g) to periodically update their preparedness and response plans and ensure that there is adequate funding;

(h) to ensure regular financial contribution to the “African Public Health Emergency Fund”;

3. REQUESTS the Regional Director:

(a) to provide technical support to Member States for the development and implementation of national outbreak prevention and control plans;

(b) to advocate for additional resources at national and international levels for the implementation of outbreak prevention and control measures in Member States, taking into account the continued threat of outbreaks of diseases including influenza;

(c) to facilitate the creation of an ‘African Public Health Emergency Fund’ that will support the investigation of and response to epidemics and other public health emergencies;

(d) to continue collaborating with the African Union and regional economic communities in strengthening disease surveillance in the African Region;

(e) to report to the sixtieth Regional Committee, and on a regular basis thereafter, depending on events on the ground.

APPENDIX 1

LIST OF PARTICIPANTS

BOTSWANA

Mr Setshwano Sebakile Mokgweetsinyana
Chief Health Officer-Disease Control

BURKINA FASO

Dr Souleymane Sanou
Directeur général de la Santé

BURUNDI

Dr Charles Batungwanayo
Directeur général de la Santé publique
Chargé des Reformes Sectorielles

CAMEROON

Dr Martin Ekeke Monono
Directeur de la Santé familiale

CAPE VERDE

Dr Ildo Augusto de Sousa Carvalho
Conselheiro Técnico

TCHAD

Dr Nantoingar Kabo Gangroh
Sécrétaire Général adjoint
Ministére de la Santé publique

CENTRAL AFRICA REPUBLIC

Dr Jean Pierre Banga-Mingo
Chargé de mission, Responsable du suivi du Plan national de Développement sanitaire II (PNDS II)

COMORES

Dr Moussa Mohamed
Directeur national de la Santé

CONGO

Pr Alexis Elira Dokekias
Directeur général de la Santé

CÔTE D'IVOIRE

Dr Félix Blédi Trouin
Directeur de Cabinet adjoint au Ministère de la Santé et de l'Hygiène publique

GAMBIA

Mr Saiku Janneh
Permanent Secretary

GHANA

Dr George Amofah
Deputy Director General
Ghana Health Service

GUINEA

Dr M'Balou Diakhaby
Conseiller chargé des questions de coopération au Ministère de la Santé et de l'Hygiène publique

LESOTHO

Dr Piet McPherson
Director Clinical Services

Mrs Masebota Khuele
Chief Health Economic Planner
Ministry of Health and Social Welfare

MADAGASCAR*

Dr Dieudonné H. Rasolomahefa
Directeur général de la Santé

MALAWI

Dr Storn Kabuluzi
Director of Preventive Health Services

MEMBRE DU CONSEIL EXÉCUTIF

Dr Neerunjun Gopee
Director General – Health Services, Mauritius

Dra. Juliana Afonso N. dos Ramos
Directora do Gabinete do Ministro da Saúde
São Tomé et Príncipe

*****Unable to attend

APPENDIX 2

AGENDA

1. Opening of the meeting
2. Election of the Chairman, the Vice-Chairman and the Rapporteurs
3. Adoption of the agenda (Document AFR/RC59/PSC/1)
4. Towards reaching health-related Millennium Development Goals: progress report and way forward (Document AFR/RC59/PSC/3)
5. Framework for the implementation of the Ouagadougou Declaration on primary health care and health systems in Africa: achieving better health for Africa in the new millennium (Document AFR/RC59/PSC/4)
6. Framework for the implementation of the Algiers Declaration on Research for Health in the African Region (Document AFR/RC59/PSC/5)
7. Public health, innovation and intellectual property: regional perspective to implement the global strategy and plan of action (Document AFR/RC59/PSC/6)
8. WHO Programme Budget 2010-2011: orientations for implementation in the African Region (Document AFR/RC59/PSC/7)
9. Drug resistance related to AIDS, tuberculosis and malaria: issues, challenges and the way forward (document AFR/RC59/PSC/8)
10. Accelerated malaria control: towards elimination in the African Region (Document AFR/RC59/PSC/9)
11. Tackling neglected tropical diseases in the African Region (Document AFR/RC59/PSC/10)
12. Policy orientations on the establishment of centres of excellence for disease surveillance, public health laboratories, food and medicines regulation (Document AFR/RC59/PSC/11)
13. Strengthening outbreak preparedness and response in the African Region in the context of the current influenza pandemic (Document AFR/RC59/PSC/12)
14. Terms of reference of the meeting of African Region delegations to the World Health Assembly and Executive Board (Document AFR/RC59/PSC/13)
15. Towards the elimination of measles in the African Region by 2020 (Document AFR/RC59/PSC/14)
16. Discussion of draft resolutions
17. Adoption of the Report of the Programme Subcommittee including the draft resolutions (Document AFR/RC59/PSC/15)
18. Assignment of responsibilities for the presentation of the Report of the Programme Subcommittee to the Regional Committee
19. Closure of the meeting.

APPENDIX 3

PROGRAMME OF WORK

DAY 1: TUESDAY, 02 JUNE 2009

9.00 a.m.–9.20 a.m.	*Registration of participants*	
9.20 a.m.–10.15 a.m.	**Agenda item 1**	Opening Ceremony
10.15 a.m.–10.25 a.m.	**Agenda item 2**	Election of the Chairman, the Vice-Chairman and the Rapporteurs
10.25 a.m.–11.00 a.m.	(*Group photo+ Tea bre*ak)	
11.00 a.m.–11.10 a.m.	**Agenda item 3**	Adoption of the agenda (document AFR/RC59/PSC/1)
11.10 a.m.–12.30 p.m.	**Agenda item 4**	Towards reaching health-related Millennium Development Goals: progress report and way forward (document AFR/RC59/PSC/3)
12.30 p.m.–2.00 p.m.	*Lunch Break*	
2.00 p.m.–3.30 p.m.	**Agenda item 5**	Framework for the Implementation of Ouagadougou Declaration on primary health care and health system in Africa: achieving better health for Africa in the new millennium (document AFR/RC59/PSC/4)
3.30 p.m.–4.00 p.m.	*Tea break*	
4.00 p.m.–5.30 p.m.	**Agenda item 6**	Framework for the Implementation of the Algiers Declaration on Research for Health in the African Region (document AFR/RC59/PSC/5)
5.30 p.m.	**End of day session**	

DAY 2: WEDNESDAY, 03 JUNE 2009

9.00 a.m.–10.30 a.m.	**Agenda item 7**	Public Health, Innovation and Intellectual Property: Regional Perspective to implement the global strategy and plan of action (document AFR/RC59/PSC/6)

10.30 a.m.–11.00 a.m.	*Tea Break*	
11.00 a.m.–12.30 p.m.	**Agenda item 8**	WHO Programme Budget 2010-2011: orientation for implementation in the African Region (document AFR/RC59/PSC/7)
12.30 p.m.–2.00 p.m.	*Lunch Break*	
2.00 p.m.–3.30 p.m.	**Agenda item 9**	Drug resistance related to AIDS, Tuberculosis and Malaria: issues, challenges and way forward (document AFR/RC59/PSC/8)
3.30 p.m.–4.00 p.m.	*Tea break*	
4.00 p.m.–5.30 p.m.	**Agenda item 10**	Accelerated malaria control towards elimination in the African Region (document AFR/R59/PSC/9)
5.30 p.m.	**End of day session**	
7.00 p.m.	***Reception offered by the Regional Director***	

DAY 3: THURSDAY, 04 JUNE 2009

9.00 a.m.–10.30 a.m.	**Agenda item 12**	Policy orientation on the establishment of Centres of Excellence for disease surveillance, public health laboratories and food and drug regulation (document AFR/RC59/PSC/11)
10.30 a.m.–11.00 a.m.	*Tea Break*	
11.00 a.m.–12.30 p.m.	**Agenda item 13**	Strengthening outbreak preparedness and response in the African Region in the context of the current influenza pandemic (document AFR/RC59/PSC/12)
12.30 p.m.–2.00 p.m.	*Lunch break*	
2.00p.m.–3.00 p.m.	**Agenda item 14**	Terms of reference of the meeting of African Region Delegations to the World Health Assembly and Executive Board (document AFR/RC59/PSC/13)
3.00 p.m.–3.30 p.m.	*Tea break*	

3.30 p.m.–5.00 p.m.	**Agenda item 15**	Towards the elimination of measles in the African Region by 2020 (document AFR/RC59/PSC/14)
5.00 p.m.–6.00 p.m.	**Agenda item 16**	Discussions of draft resolutions
6.00 p.m.	**End of day session**	

DAY 4: FRIDAY, 05 JUNE 2009

16 p.m.–16.30 p.m.	**Agenda item 16**	Adoption of the report of the Programme Subcommittee including he draft resolutions (document AFR/RC58/PSC/14)
	Agenda item 17	Assignment of responsibilities for the presentation of the report of the Programme Subcommittee to the Regional Committee
	Agenda item 18	**Closure of the meeting.**